Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HCA TEXAS ORTHOPEDIC HOSPITAL
3701 KIRBY DRIVE, STE 1288
HOUSTON, TX 77098-3926

Respondent Name
UNIVERSITY OF TEXAS SYSTEM

Carrier's Austin Representative Box
Box Number 46

MFDR Tracking Number
M4-05-2077-01

MFDR Date Received
NOVEMBER 9, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The hospital's representative believed that authorization would be provided upon receipt of all the patient's clinicals. Our client provided the necessary clinical on the patient, but was never provided an authorization number in this matter. It is our position that the hospital acted properly in seeking a pre-certification in this matter."

Amount in Dispute: $5,208.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per TWCC Rules, a surgical procedure required pre-authorization and Texas Orthopedic Hospital did not follow the appropriate procedure to obtain pre-authorization for the surgery that Dr. Mehlhoff performed on [injured employee] on 11/21/03. The operative report of Dr. Mehlhoff also shows that the surgery was performed 18 days after the date of injury so an emergency need to perform the surgery cannot be supported. "

Response Submitted by: Medical Business Management Services, P.O. Box 20196, Houston, TX 772255-0196

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 21, 2003	Outpatient Hospital Services	$5,208.19	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. 28 Texas Administrative Code §134.600 set out the guidelines for services which require preauthorization.

4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on November 9, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 22, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - A-Preauthorization required but not obtained.
   - O-Denial after reconsideration.
   - A-Preauthorization required but not obtained. Does not qualify as emergency.

Findings

1. The insurance carrier denied disputed services with denial code A - " A- Preauthorization required but not obtained. Does not qualify as emergency." Division rule at 28 TAC §134.600(b), effective January 1, 2003, 27 TexReg 12359; states that "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury: (1) listed in subsection (h) or (i) of this section, only when the following situations occur: (A) an emergency, as defined in §133.1 of this title (relating to Definitions); (B) preauthorization of any health care listed in subsection (h) of this section was approved prior to providing the health care..." Division rule at 28 TAC §133.1(a)(7)(A), effective July 15, 2000, 25 TexReg 2115; defines an emergency as "the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health and/or bodily functions in serious jeopardy, and/or serious dysfunction of any body organ or part." Division rule at 28 TAC §134.600(h), effective January 1, 2003, 27 TexReg 12359; states, in pertinent part, that the non-emergency health care requiring preauthorization includes "(11) all durable medical equipment (DME) in excess of $500 per item (either purchase or expected cumulative rental)…" Review of the documentation submitted by the requestor finds that the requestor has not submitted documentation to support a medical emergency as defined in Division rule at 28 TAC §133.1. Nor did the requestor present documentation to support preauthorization as required under §134.600(h). This denial code is therefore supported.
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "The hospital's representative believed that authorization would be provided upon receipt of all the patient's clinicals. Our client provided the necessary clinical on the patient, but was never provided an authorization number in this matter. It is our position that the hospital acted properly in seeking a pre-certification in this matter."
   - The requestor did not submit documentation to support that preauthorization was obtained in accordance with 28 Texas Administrative Code §134.600(b).
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		11/29/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.